2011 Mandated Benefits Data Call Instructions (to accompany Form LHL657)

Reporting Period: October 1, 2010 - September 30, 2011

Introduction

The Texas Department of Insurance (TDI) has provided the following instructions to help companies in the filing of data relating to mandated health benefits and mandated offers of coverage as required under 28 Texas Administrative Code (TAC) §§21.3401–21.3409 (Chapter 21, Subchapter Z). Companies will complete and submit the 2011 data call using an interactive PDF form rather than the traditional online application. The new PDF form does not require a password.

A company is exempt from filing the forms relating to **individual** coverage if the 2010 annual statement indicates a total of less than **$2 million** in direct premiums for individual policies in Texas. A company is exempt from filing the forms relating to **group** coverage if the 2010 annual statement indicates less than **$10 million** in direct premiums for group policies in Texas. Companies may refer to 28 TAC §21.3401 for additional information on the applicability of the data call.

Each company required to file a report must submit a reporting form. Respondents should not consolidate information from different companies on one reporting form. Companies should indicate on the form cover sheet whether they are responding as an Accident and Health (A&H) issuer or a Health Maintenance Organization (HMO). Companies that have both A&H and HMO business must file a separate form for each. Companies should use one form to report individual and group coverages as noted on Form LHL657.

When completing the data call, refer to the information provided on the Mandated Benefits Data Call Index Page (Index Page) at www.tdi.texas.gov/health/mbindex.html. The file titled "Mandated Benefits Data Call Code List" includes applicable codes from both the Physicians' Current Procedural Terminology (CPT) and the International Classification of Diseases (ICD). These codes may assist companies in identifying claims data related to the various mandated benefits and offers. This file may not include all relevant codes due to the variation among companies' reporting requirements and claims filing procedures. Therefore, companies should use these codes as a reference tool but may add additional codes as appropriate.

The Index Page also includes statutory citations and detailed descriptions for each mandated benefit and offer of coverage. Because some mandated benefits apply only to specific groups of people, companies should carefully review these descriptions and only report claims for insureds covered by the applicable mandated benefit requirement. Companies are responsible for ensuring that reported data is consistent with Texas statutory requirements.

Example: The mammography screening mandated benefit applies only to women aged 35 and older. As such, you should not report mammography claims data for women under age 35 or for any men.

Terminology

These instructions and other materials associated with the 2011 Mandated Benefits Data Call use generic terminology. For the purpose of this data call, please consider the following terms equivalent in meaning:

- Company – means A&H insurer or HMO, as applicable
- Policy – means policy or evidence of coverage (EOC), as applicable
- Certificate – means certificate or EOC, as applicable
- Claim – means claim or medical expense, as applicable

Data Call Overview

Companies must complete the 2011 data call using an interactive PDF form that is available on the TDI website under the designation "LHL657" at www.tdi.texas.gov/health/mbindex.html. This form contains fields that will be completed on-screen. Respondents must have installed Adobe reader 9.0 (or higher) to ensure proper form functionality.

Form LHL657 contains a "Submit by Email" button that will convert the data in the PDF form to an XML attachment. This XML file is due to TDI via email at MBSurvey@tdi.state.tx.us by **December 1, 2011**. Companies that are unable to respond with accurate data by December 1, 2011, may contact TDI via email at MBSurvey@tdi.state.tx.us by November 28, 2011, to request an extension. TDI will only accept surveys returned in XML format using the prescribed form; **TDI will not accept any survey returned in a different format, including scanned PDF files**.

Form LHL657 has eight sections:

- Cover Sheet
- Part A: Claim Information for Individual Benefits
- Part B: Claim Information for Group Benefits
- Part C: Premium Information for Individual Benefits
- Part D: Premium Information for Group Benefits
- Part E: Mandated Benefit Claims Identification
- Part F: Additional Information
- Part G: Data Certification

Cover Sheet

Companies must provide all requested company identifying information, including the NAIC company number, NAIC Group number, company name, group name, and complete mailing address. Companies must also provide information about the company's primary contact individual, including the person's name, title, direct phone number, mailing address, and email address.

Companies must then provide total premiums written and total claims paid for all health benefit plans subject to the mandated benefit/offer requirements in Texas during the reporting period. This information is required for each of the coverage categories captured by the data call, as follows:

- **Total premiums written for applicable individual health benefit plans:** This amount includes the total premium written in Texas on applicable individual policies that are subject to mandated benefits and offers for the reporting period. Include only written premiums on applicable policies. Round responses to the nearest dollar.
- **Total claims paid for applicable individual health benefit plans:** This amount includes the total dollar amount of all claims paid on applicable individual policies that are subject to mandated benefits and offers for the reporting period. This total amount includes claims paid for **all** covered services, including both mandated benefits and claims for **all** other covered services. Round responses to the nearest dollar.
- **Total premiums written for applicable group health benefit plans:** This amount includes the total premium written in Texas on applicable group policies that are subject to mandated benefits and offers for the reporting period. Include only written premiums on applicable policies. Round responses to the nearest dollar.
- **Total claims paid for applicable group health benefit plans:** This amount includes the total dollar amount of all claims paid on applicable group policies that are subject to mandated benefits and offers for the reporting period. This total amount includes claims paid for **all** covered services, including both mandated benefits and claims for **all** other covered services. Round responses to the nearest dollar.

Companies that did not have applicable business in a specific coverage category should enter $0 for both premiums and claims in that category on the cover sheet.

Finally, companies must indicate if they offered individual health benefit plans subject to mandated benefits and offers with premiums in excess of $2 million for the reporting period. Companies that indicate “No” may leave Parts A and C blank. Companies must also indicate if they offered group health benefit plans subject to mandated benefits and offers with premiums in excess of $10 million for the reporting period. Companies that indicate “No” may leave Parts B and D blank. Companies that answer “No” to both of these questions may proceed to Part G.

Claim Information worksheets (Parts A-B)

This section requires specific claim data for each mandated benefit and mandated offer. **Companies must complete the detailed claim and premium worksheets for each applicable coverage category (individual, group) as indicated on the cover sheet. Companies should leave these detailed worksheets blank for any coverage category that does not apply.** Refer to the list of suggested ICD and CPT codes on the Index Page, and described on Page 1 as a reference when compiling this data.

- **Number of Claims Paid:** Enter the total number of separate claims paid for each mandated benefit/offer during the reporting period.
- **Total Mandated Benefit Claims Paid:** Enter the total dollar amount of claims paid for each mandated benefit/offer. Round responses to the nearest dollar.
- **Number of Individual Policies or Group Certificates:**
  - **Individual business:** Enter the number of individual policies that provided coverage for each specified mandated benefit/offer. Include policies issued or renewed in Texas during the reporting period. Each primary insured represents one individual policy.
  - **Group business:** Enter the number of small group **certificates** (not the number of group contracts) that provided coverage for each specified mandated benefit/offer. Include certificates issued or renewed in Texas during the reporting period. Each enrolled employee represents one group certificate.
- **Annual Administrative Cost:** Enter the total annual administrative costs directly associated with each mandated benefit/offer. Start-up costs, such as the cost of revising policy forms during the first year a company implements a new mandate, should not be included unless the company incurred those costs during the reporting period. Responses should reflect the total cost to the company and be rounded to the nearest dollar. Companies may use a logical allocation base to derive these costs. Each company has discretion to determine the most logical allocation methodology.

If the company has claims to report for a specific mandate in a specific coverage category, complete all data columns for that mandate (including the number of claims paid, value of claims paid, number of policies/certificates, and annual administrative cost) on the Claim Information worksheet.

Premium Information worksheets (Parts C-D)

Table 1 on each Premium Information worksheet requires companies to indicate the average annual premium paid by primary insureds for each mandated benefit/offer during the reporting period. Provide data separately for individual and group health benefit plans. Within each of

these coverage categories, report data separately for members enrolled in single coverage and members enrolled in family coverage. **If you report claims data for a specific mandate in a specific coverage category on the Claim Information worksheet, you must also provide average annual premium data for that mandate on the corresponding Premium Information worksheet.**

Table 2 on each Premium Information worksheet requires companies to indicate the number of individual policies or group certificates issued or renewed during the reporting period and the number of policies/certificates in force on the last day of the reporting period. Table 3 requires similar information for the number of lives covered under these policies/certificates.

Following is additional detail on the data requested in these tables.

- **Average Annual Premium Cost per Policy/Certificate Attributable to Each Mandate:** This section requires companies to estimate the average premium in dollars paid by primary insureds for each mandated benefit and mandated offer during the reporting period. **Report this data on the policy level for individual plans, and report it on the certificate level for group plans.** Provide annual premium costs separately for single coverage (primary insured only) and family coverage (primary insured plus all dependents, including spouse and children). These categories represent the least and most expensive coverage tiers. Do not provide premium information for the other available coverage tiers, such as "plus spouse" and "plus children."

  You must base the premium estimates on the company's actual claims experience as disclosed in the "Claim Information" worksheets in this data call. If average costs across all applicable policies/certificates cannot be determined, base your estimate on the company's most popular standard policy/certificate in the appropriate coverage category. Provide data separately for individual and group health benefit plans.

  When entering data for this section, round dollar amounts to the nearest cent. The dollar sign ($) will appear once you enter your data. You must use a decimal for any value that includes cent amounts, such as $2.25. Without the decimal, the value will display incorrectly in total dollars so that $2.25 becomes $225. It is not necessary to enter a decimal point and zeroes for a whole dollar amount, such as $2.00.

  Example: If you estimate the average annual cost of providing benefits for mammography screening at $4.00 for individual policies covering a single person and $5.25 for individual policies that provide family coverage, you will enter ***4.00*** or ***4*** under the column heading "Single" and ***5.25*** under the column heading "Family."

  Form LHL657 includes calculated fields at the bottom of Table 1 that display the sum of reported premiums for single and family coverage. **Companies should verify that the**

stated totals accurately reflect the average premium paid by each primary insured for the specified mandates for 12 months of coverage.

- **Number of Policies/Certificates:** On the first line, provide the total number of applicable individual policies or group certificates issued or renewed during the reporting period. Report this data separately for policies/certificates providing single coverage and policies/certificates providing family coverage.

  On the second line, provide the total number of individual policies or group certificates in force on the last day of the reporting period. Report this data separately for policies/certificates providing single coverage and policies/certificates providing family coverage.

- **Number of Lives Covered:** On the first line, provide the total number of lives covered under individual policies or group certificates issued or renewed during the reporting period. Report this data separately for policies/certificates providing single coverage and policies/certificates providing family coverage. Include all covered family members in the calculations for family coverage. This includes primary insured, spouse, and all dependents.

  On the second line, provide the total number of lives covered under individual policies or group certificates in force on the last day of the reporting period. Report this data separately for policies/certificates providing single coverage and policies/certificates providing family coverage. Include all covered family members in the calculations for family coverage. This includes primary insured, spouse, and all dependents.

Mandated Benefit Claims Identification worksheet (Part E)

This worksheet requires companies to indicate the ICD and/or CPT codes used to identify applicable claims for each mandated benefit or mandated offer of coverage. You should indicate which diagnosis index (ICD-9, ICD-10) your company uses in the Additional Information section (Part F). This information will allow TDI to better understand companies' data and identify potential causes of data inconsistencies between responding companies.

- In cases where you use a **single ICD or CPT code** to identify applicable claims, simply specify that code. For example, if you identified osteoporosis detection claims by the presence of ICD code V82.81, you should enter ***ICD V82.81 only***.
- In cases where **only one in a series of similar ICD or CPT codes** was used to identify applicable claims, list all acceptable codes with the "OR" parameter. For example, if AIDS/HIV claims were identified by the presence of ICD code 042, 079.53, V08, 136.3, or 795.71, you should enter ***ICD 042, 079.53, V08, 136.3, OR 795.71***.

- In cases where **two codes must both be present** to identify applicable claims, list both acceptable codes with the "AND" parameter. For example, if in vitro fertilization claims were identified by the presence of ICD 628.X in conjunction with CPT 89250, you should enter ***ICD 628.X AND CPT 89250***.
- In cases that are more complex, expand and/or combine the guidelines outlined above to be as clear and descriptive as possible. For example, assume mammography claims require both a specific CPT code (76092) and one of two possible ICD codes (V76.11 OR V76.12). In this case, you could enter either of the following:

  – ***CPT 76092 AND (ICD V76.11 OR ICD V76.12)***
  – ***CPT 76092, plus either ICD V76.11 or ICD V76.12***

  If applicable, also identify additional query constraints that are relevant to a specific benefit, such as a specific patient age range. For example, the mammography responses above should also include ***limited to females aged 35 and older.***

Additional Information (Part F)

The "Additional Information" memo field gives companies the opportunity to provide important information to TDI about their data. This field can contain data clarifications or explanations regarding certain calculation methodologies. You should also indicate here which diagnosis index (ICD-9, ICD-10) you used to complete Part E. **This field is required if any of the following conditions apply:**

- If any requested data is **not applicable**, you must identify these fields and describe why they do not apply.
- If any requested data is **not available**, you must identify these fields and provide a detailed explanation of why you are unable to provide this information.
- If any block of business captured by the data call is **closed or in run-off**, you must identify the applicable coverage category (individual, group) and the number of lives covered by that block of business.

Data Certification (Part G)

After entering all required data, complete the Data Certification fields at the end of the last page of form LHL657. **You will not be able to submit your company's data if the Data Certification fields are incomplete.**

After checking the box next to the attestation statement, enter the name, title, and phone number of a person with the authority to certify your company's data. This individual should be a corporate officer, actuary, attorney, or accountant. If an authorized agent is completing the data call on behalf of this individual, include both parties in the "Name" field at the bottom of the

form. (For example, you could enter ***Bob Jones, on behalf of Pam Smith***.) However, the "Title" field should specify the title of the person with the authority to certify your company's data. A separate affidavit is not required.

Interactive Form Instructions

Form LHL657 contains form fields that companies will complete on-screen using Adobe reader 9.0 (or higher). You can then print the PDF form or export the form data to a separate file after completion. Following are instructions on how to complete and submit the data collection form.

- Select the Hand tool or use the tab key to navigate between form fields.
- To make form fields easier to identify in the PDF file, do any of the following in the Document Message Bar:

  - To display a light blue color in the background of all form fields, select *Highlight Fields*.
  - To display a red outline around all form fields that you are required to fill, select *Highlight Required Fields*. (Using this option will display the form's required fields.) **You will not be able to submit form LHL657 if you have not completed all required fields.**

- The form fields are preformatted, and the correct formatting will appear when you tab to the next field. The following examples demonstrate the correct data entry format.

  - **Round currency fields on the cover sheet and the detailed claim worksheets to the nearest dollar** and enter without any formatting. For example, you should enter $500,000 as ***500000***.
  - **Round currency fields on the detailed premium worksheets to the nearest cent**. For example, for an average premium of $5.25 enter ***5.25***.
  - **Enter numerical (non-currency) fields on the detailed claim worksheets without any formatting**. For example, enter 2,500 claims as ***2500***.
  - **The form will not accept text responses in numerical or currency fields.** If requested data is either not applicable or not available, you must provide an adequate explanation in Part F (Additional Information) as described on Page 7.

- Companies must complete the detailed Claim Information and Premium Information worksheets for each applicable coverage category (individual, group) as indicated on the cover sheet. Companies should leave these detailed claim and premium worksheets blank for any coverage category that does not apply.
- If the company has claims to report for a specific mandate in a specific coverage category, you must complete all data columns for that mandate (including the number of claims paid, value of claims paid, number of policies/certificates, and annual

administrative cost) on the Claim Information worksheet. You must also provide average annual premium data for that mandate on the corresponding Premium Information worksheet.

Data Submission Instructions

After completing the PDF form as described above, print the form for your records by clicking the "Print Form" button located at the bottom of the form. You will not be able to save the completed form. Then, submit the file to TDI as follows:

- If you are using a **desktop email application**, open your applicable email application before attempting to submit the form. Then, click the "Submit by Email" button located at the bottom of the form. A new email message with an XML file attachment should appear. Address the message to MBSurvey@tdi.state.tx.us, and ensure the subject of the message reads "2011 Mandated Benefits Data Call" followed by your company's NAIC number.
- If you are using an **internet-based email application**, such as Gmail, Hotmail, etc., the Select Email Client dialog box will appear after you click the "Submit by Email" button located at the bottom of the form. Select the "Internet Email" option, and then click OK. Save the survey file as an XML file using the default filename (lhl657.xml). Then, open your internet-based email application and attach the XML file to your email. Address the message to MBSurvey@tdi.state.tx.us, and enter "2011 Mandated Benefits Data Call" as the subject of the message. Include the company's name and NAIC number in the body of the message.

As stated previously, you will not be able to submit form LHL657 if you have not completed all required fields. If a required field is blank when you click the "Submit by Email" button, you will receive an error message and a red border will appear around the field(s) that requires completion. Once all such fields are completed, you may try to submit your data again using the "Submit by Email" button.

After you have submitted your file, TDI will send an acknowledgement receipt via email. You may wish to send a follow-up email to MBSurvey@tdi.state.tx.us if you have not received a confirmation message within two business days.

To ensure that company data is complete and processed correctly, TDI will only accept surveys returned in XML format as described above. TDI will not accept any survey returned in a different format, including scanned PDF files.

Send all questions concerning the Mandated Benefits Data Call via email to MBSurvey@tdi.state.tx.us.